CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE (CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPI	
		155115	B. WIN	IG		03/10/2	2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET	TADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUFFLIER			1121 [E LASALLE AVE		
		REHABILITATION CENTER			H BEND, IN46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	IAG	DEFICIENCE!		DATE
F0000	This visit was for	r Investigation of	F00	000	The creation and submission		
	Complaint IN000	087056.			this Plan of Correction does r		
	_				constitute an admission by the provider of any conclusion se		
	Complaint IN000	087056- Substantiated,			forth in the statement of		
	Federal/State def	iciencies related to the			deficiencies, or of any violation	n of	
	allegations are ci				regulation. This provider		
	F-157, F-225, F-				respectfully requests that the		
	,1				2567 Plan of Correction be considered the Letter of Cred	ihla	
	Unrelated deficie	ency cited			Allegation and requests a De		
	omenated deficie	noj onou			Review in lieu of a Post Surv		
	Survey dates: March 7, 8, 9 and 10, 2011				Review on or after April 7, 20		
	Survey dates: March 7, 8, 9 and 10, 2011						
	F	000048					
	Facility number:						
	Provider number						
	AIM number:	100275330					
	G.						
	Surveyor:						
	Mary Anne Cilell	la, RN.					
	Census bed type:						
	SNF/NF: 117						
	Total: 117						
	Census payor typ	oe:					
	Medicare: 1						
	Medicaid: 8						
		20					
	Total: 11						
	101. 11	L /					
	Sample: 6						
	Sample: 6	manle. O					
	Supplemental Sa	mpie: 9					
		1 0					
	These deficiencie	es also reflect state					
I A BOR ATOR	V DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SU	CNATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3KOM11

Facility ID:

000048

If continuation sheet

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155115		A. BUILDING	UNSTRUCTION	COMP 03/10/2	LETED	
		100110	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	ł		ADDRESS, CITY, STATE, ZIP CO	ODE	
СФРПИ	AL NITBRING AND I	REHABILITATION CENTER		E LASALLE AVE H BEND, IN46617		
				11 D⊑ND, IN 4 0017		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION	(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		accordance with 410 IAC				
	16.2.					
	16.2. Quality review c 2011 by Bev Fau	ompleted on March 15, alkner, RN.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		IDENTIFICATION NUMBER:	A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/10/2011		
NAME OF F	ROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE		
CARDINA	AL NURSING AND I	REHABILITATION CENTER	SOUTH BEND, IN46617				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F0157	Based on interviews and record reviews,		F01	57	F 157 It is the practice of this	, the	04/07/2011
SS=D	the facility failed to notify the physician				provider to immediately inform resident, consult with the resident		
		s legal representative of			s physician, and if known, noti	fy	
	-	on the entire buttocks,			the resident's legal representa		
	-	d the breast area of 1			or an interested family member	er	
	resident who was	s sent to the hospital			when there is an accident involving the resident which		
	when the bruisin	g was identified in the			results in injury and has the		
	sample of 6 revie	ewed for physician			potential for requiring physicia	n	
	notification.				intervention; a significant char		
					in the resident's physical, mer		
	Resident: B				or psychosocial status; a need alter treatment significantly; or		
					decision to transfer or discharge		
	Findings include	:			the resident from the		
	C				facility. What corrective		
	Review on 3/8/1	1 at 4:00 p.m., of the			action(s) will be accomplished	∍d	
		ncy department physician			for those residents found to		
		1 3/2/11, indicated			have been affected by the deficient practice · Resident	· #	
		examined and had			B: Resident's bruising was	۱#	
		ing, especially on the			addressed with the physician	on	
	-	nt thigh extending down			3/2/11. Licensed nurses were		
	•	al area. Bruising was also			re-educated on the Change of		
		•			Condition Policy and Procedul on 3/29/11. The Interdisciplination		
		anus. No perineal			Team continues to monitor the	-	
	C	served. The resident also			Hour Report Sheet and Physic		
		atoma on the left side of			Order Forms for resident char		
		h some bruising. This			of condition. The resident has		
	-	the bruising appeared to			experienced no negative outcomes as a result of the alleged defice		
	, ,	ration suggesting minor			practice. How will you identif		
	trauma.				other residents having the	,	
					potential to be affected by th	е	
		osed clinical record of			same deficient practice and		
		7/11 at 11:25 a.m.,			what corrective action will be	9	
	indicated the resi	ident's diagnoses			taken · Residents who experience a change of condit	tion	
	included, but we	re not limited to			have the potential to be affect		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC		COMPLI	ETED
		155115				03/10/20	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER			1			
CARRIN	AL AULIDOING AND	DELIA DIL ITATIONI OFNITED		1	LASALLE AVE		
CARDINA	AL NURSING AND I	REHABILITATION CENTER		SOUTH	H BEND, IN46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	$\overline{}$	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Parkinson's disea	se and dementia with			by the alleged deficient praction		
	psychosis. The r	resident resided in the			To ensure physicians are notif		
		r to her transfer to the			of a resident change of status	: -	
	hospital.	to her transfer to the			Licensed nurses were		
	ilospitai.				re-educated to the facility Cha		
					of Condition Policy and Proce on 3/29/11, by the Director of	Jule	
		Iinimum Data Set (MDS)			Nursing/Designee.		
	assessment, date	d 2/11/11, indicated the			Noncompliance with facility po	olicy	
	resident had diso	rganized thinking			and procedure may result in	·,	
		ibited physical and verbal			employee disciplinary action u	ip to	
	1 ^	ds others. The resident			and including termination.	.	
	* *	ve assistance with all			What measures will be put	t	
	_				into place or what systemic		
	1	living and was able to			changes you will make to		
		sistance from staff. The			ensure that the deficient		
	resident also util	ized a walker.			practice does not recur		
					Resident status change is place		
	During interview	on 3/9/11 at 2:45 p.m.,			on the "24 Hour Report Sheet"	·	
		o gave the resident a			and the resident will have a documented assessment ever	, l	
	l '	the CNA indicated she			shift for no less than 72 hours		
					applicable, or until the residen		
		of the new and fresh			condition stabilizes. • The	``	
		ident's breast area and			"Physician Order" form is utiliz	ed	
	buttocks. The CN	NA indicated the nurse			for physician orders or change		
	(LPN#1) proceed	led to measure the areas.			resident status that require a		
					change in the resident's plan		
	Review of the sh	ower sheet for 3/1/11			care. Notification of family and	d	
		had documented "all			physician is recorded on this		
					form. · The interdisciplinary to will review the "24 Hour Report		
	~	d in tx (treatment) book			and "Physician Order" forms for		
	on purple sheets.	"			physician and family notification		
					at the Clinical morning meetin		
	Review of the wo	ound skin evaluation			Monday thru Friday. The	·	
	report (purple sh	eets) indicated multiple			interdisciplinary team determine	nes	
		iple bruising, but all the			if any further interventions or		
		d 2/27/11. No new			changes to the plan of care is		
		description of new			necessitated. The Unit Manag	jer,	
	incasurements of	description of new			or designee, will ensure		
			I		1		

Facility ID:

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		155115	A. BUILDING		03/10/2011
		100110	B. WING		
NAME OF P	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE	
				LASALLE AVE	
CARDINA	AL NURSING AND	REHABILITATION CENTER	SOUTH	H BEND, IN46617	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	bruises were doc	cumented and it could not		implementation. The Nurse	
	be determined th	ne status of the bruising as		Manager-On-Call will be notifi	
		ospital emergency		of acute resident change of st	
	•			during non-business hours. T	
	department repor	It.		Nurse Manager-On-Call will n	- I
				the Director of Nursing Service	
	Nurses' notes lac	eked documentation the		and/or the Executive Director,	I
	physician or the	guardian had been		deemed necessary. Charge	:
	notified of the bi	· ·		nurses will review the	
	liounica of the of	ruising.		Medication/Treatment	_
				Administration Records during shift report to ensure that	}
	During interview	with the Administrator		medications/treatments are gi	won
	and the Director	of Nursing on 3/08/11 at		and documented and that	ven
	11:00 a.m. thev	indicated the physician		physicians are notified of a	
	, ,	had not been notified.		resident change of condition.	
	_			How the corrective action(s	.,
	The Administrat	or indicated LPN#1 felt it		will be monitored to ensure	·
	wasn't necessary	since the responsible		deficient practice will not re	****
	party was a guar	dian and not a member of		i.e., what quality assurance	, ui,
	the immediately			program will be put into place	
	the ininiculatory	Turring.		• The physician orders and	
				24 Hour Report sheets are	ine
		relates to Complaint		reviewed by the Unit Manager	re
	IN00087056.			and/or designee, to ensure	•
				resident change of condition i	e l
	3.1-5(a)(2)			reported to the physician,	'
	$\int J(1) J(\alpha)(2)$			physician orders are followed	
				through timely, and care plans	3
				are updated. · A "Changer of	
				Condition" CQI tool will be util	l l
				weekly x 4, monthly x 2, and	
				quarterly, thereafter, to monitor	or
				the Medication/Treatment	
				Administration Records for	
				compliance with administratio	n,
				documentation, and physiciar	ı
				notification, if applicable. The	;
				audits are reviewed by the CC	
				committee and action plans a	re
				developed, as needed, to imp	rove

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/10/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE	
CARDINA	AL NURSING AND F	REHABILITATION CENTER		H BEND, IN46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E COMPLETION
			1	(EACH CORRECTIVE ACTION SHOULD BECOSS-REFERENCED TO THE APPROPRIATE OF	DATE ate nges

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		ONSTRUCTION	(X3) DATE S COMPL	ETED
		155115	B. WIN	G		03/10/2	011
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					LASALLE AVE		
CARDINA	AL NURSING AND F	REHABILITATION CENTER		SOUTH	I BEND, IN46617		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0225		ews and record reviews,	F02	25	F 225		04/07/2011
SS=D	_	to ensure injuries of			It is the practice of the provider to	,	
	unknown origin v	•			ensure that all alleged violations	,	
	immediately to the	ne Administrator of the			involving mistreatment, neglect, of	or	
	facility and other	officials in accordance			abuse including injuries of unkno	wn	
	with state law thr	ough established			source and misappropriation of		
	procedures. This	deficient practice related			resident property are reported	- c	
	to 1 of 1 depende	ent residents in the			immediately to the administrator the facility and to other officials i		
	-	was found with diffuse			accordance with State law through		
	bruising on the en	ntire buttocks, thighs and			established procedures (including		
	around the breast				the State survey and certification		
					agency).		
	Resident: B						
					What corrective action(s) will be accomplished for those residents		
	Findings include				found to have been affected by t		
	i mamga merade	•			deficient practice		
		1 at 4:00 p.m., of the			Resident B no longer resident	les	
		cy department physician			in the facility.		
	evaluation, dated	3/2/11, indicated			Resident B's injury of		
	Resident B was e	examined and had			unknown origin was reported to t	he	
	significant bruisi	ng, especially on the			appropriate agencies and		
	inside of her righ	t thigh extending down			administrator on 3/2/11.		
	to the right glutea	al area. Bruising was also					
	noted around her	anus. No perineal					
	bruising was obs	erved. The resident also					
	had a small hema	atoma on the left side of					
	her forehead with	n some bruising. This			How will you identify other	L .	
		he bruising appeared to			residents having the potential to affected by the same deficient	pe	
	•	ration suggesting minor			practice and what corrective		
	trauma.	55 5			action will be taken		
	Review of the cla	osed clinical record of			Residents residing in the		
		7/11 at 11:25 a.m.,			facility have the potential to be affected by the alleged deficient		
		,, 11 W 11.00 Willing			anceted by the aneged deficient		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING		COMPL	ETED
		155115	B. WIN			03/10/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		1	I BEND, IN46617		
				<u>l</u>			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG			DATE
		ident's diagnoses			practice.	.	
included, but were not limited to					 A facility wide skin sweep was completed by the Licensed 	P	
	Parkinson's disea	ase and dementia with			nurses on 3/3/11 to ensure no oth	ner	
	psychosis. The	resident resided in the			skin alterations including bruises		
	secured unit price	or to her transfer to the			other injuries.		
	hospital.				Any identified concerns v	vill	
					be corrected as necessary and/or		
	The admission Minimum Data Set (MDS)				reported to administrator or design		
		d 2/11/11, indicated the			and state agencies as indicated in	the	
					facility policy.		
		organized thinking					
	_	ibited physical and verbal			What measures will be put into		
	symptoms towar	ds others. The resident			place or what systemic changes		
	required extensive	ve assistance with all			you will make to ensure that the		
	activities of dail	y living and was able to			deficient practice does not recu		
	ambulate with as	ssistance from staff. The			-		
	resident also util	ized a walker.			· Facility staff were		
					re-educated on the Abuse		
	Review of the nu	urses' notes from 2/18/11			Prohibition, Reporting and		
		ed the following:			Investigation policy & procedur		
	10 3/2/11 marcat	ed the following.			the Ombudsman on March 23, 20	011.	
	0/10/11 1				L.P.N. #1 is no longer employed at the facility.		
		l confused, made several			· Staff were re-educated		
	attempts to get o				regarding facility policy & proce	dure	
	2/19/11 restless	, constantly getting up and			for investigation of injuries of		
	trying to walk. p	hysically aggressive,			unknown source.		
	constantly movin	ng.			· Staff re-education regardi	ng	
		constantly getting up,			timely reporting of unusual		
	poor safety awar				occurrences or injuries of unknown	wn	
	1 ^	1:1 care for safety			origin to the Administration or	_	
		tantly standing up and			designee and other state agencies Emphasizing the importance of	S.	
					adhering to these policies &		
	trying to get out				procedures.		
	1	lown, tries to walk and			prosouures.		
	was tired within				How the corrective action(s) wi	11	
	2/25/11 up durin	g night, constantly rolling			be monitored to ensure the		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING		COMPL	ETED
		155115	B. WIN			03/10/2	011
		<u> </u>	P. (/11		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		1	H BEND, IN46617		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΈ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	herself on floor				deficient practice will not recur	,	
	2/26/11 up at 2:3	30 a.m., unable to sit still.			i.e., what quality assurance program will be put into place		
	2/27/11 up and down as usual				program win be put into piace		
	2/28/11 difficult to keep in bed, up within				· An "Abuse Prohibition ar	ıd	
	five minutes. When ambulating wants to				Investigation" CQI tool will be		
	sit down, just dr	ops and staff has to catch			completed by the Director of		
		else she ended up on the			Nursing/Designee Weekly X's 4		
	floor.				weeks, Monthly X's 2 months, a	nd	
		o ensure no falls. Edema			Quarterly thereafter.		
	noted in both fee				· Any identified trends or concerns will be addressed		
	1				immediately.		
	· ·	sat on the floor . Physician			Data will be submitted to	the	
		nt sent to the hospital for			CQI committee for review and a		
		ubsequently admitted.			plans initiated as needed.		
		was lacking in the nurses'					
	notes to indicate	any bruising was noted.			What is the date by which the		
					systemic changes will be comple	eted	
	During interview	v on 3/9/11 at 2:45 p.m.,					
	with CNA#3, wl	ho gave the resident a			Compliance Date: April 7, 2011		
	· ·	1, indicated she notified					
		ew and fresh bruises to the					
		area and buttocks. The					
		he nurse (LPN#1)					
	proceeded to me	, ,					
	proceeded to me	asure the areas.					
	D						
	1	nower sheet for 3/1/11					
	1	l had documented "all					
	1	d in tx (treatment) book					
	on purple sheets	•					
		round skin evaluation					
	report (purple sh	neets) indicated multiple					
	sheets with mult	iple bruising, but all the					
	sheets were date	d 2/27/11. No new					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
1111212111	or continue from	155115		LDING		03/10/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	LASALLE AVE		
		REHABILITATION CENTER		SOUTH	I BEND, IN46617		
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PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		description of new		IAG			DATE
		umented and it could not					
		e status of the bruising as					
	reported in the hospital emergency						
	department report.						
	During interview	with Administrator and					
	LPN#1 on 3/10/1	1 at 9:20 a.m., the LPN					
	indicated she was	s the nurse in charge of					
	the resident. She	stated no one told her					
	about the bruises	around the breast area					
	and thigh area. S	She didn't remember					
		neasuring the areas.					
	When the Admin	•					
	-	about the CNA telling her					
		darker bruises, she					
		indicated she did not do					
		nem because she thought					
		y noted on the purple					
		ated she should have					
	-	ts and initialed new ones					
		or the fresh bruises. She					
		she paged the supervisor sn't in the facility yet and					
	nothing more wa	• •					
	_	dicated neither she nor					
		fursing Service were					
		ensive bruising until after					
		sent to the hospital.					
		1 .					
	This federal tag r	relates to Complaint					
	IN00087056.						

l		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115	TIFICATION NUMBER:		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE	
CARDINA	AL NURSING AND I	REHABILITATION CENTER		H BEND, IN46617	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
_	3.1-28(c)				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155115	B. WIN			03/10/2011
NAME OF I	DROVIDED OD SUDDUJED		'	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1121 E	LASALLE AVE	
		REHABILITATION CENTER			H BEND, IN46617	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
		LSC IDENTIFYING INFORMATION)	F02		F 226	
F0226		ews and record reviews,	F02	26	F 220	04/07/2011
SS=D	•	to ensure written			It is the practice of the provider to	
		redures that prohibit			ensure that all alleged violations	
		glect and abuse of			involving mistreatment, neglect,	
		plemented related to the			abuse including injuries of unkno	own
		nsive bruising of a			source and misappropriation of	
	suspicious nature	e and of unknown origin			resident property are reported immediately to the administrator	of
	immediately to th	ne Administrator of the			the facility and to other officials i	
	facility and other	officials in accordance			accordance with State law through	
	with state law the	rough established			established procedures (including	l l
	procedures. This deficient practice related				the State survey and certification	
	-	s in the sample of 6 who			agency).	
		extensive bruising of an				
	unknown nature.	8			What corrective action(s) will be accomplished for those resident	
					found to have been affected by t	
	Resident: B				deficient practice	
	resident. B				_	
	Findings include			Resident B no longer resid	les	
	Tillulings illetude	•			in the facility.	
	Daniana an 2/9/1:	1 -4 4.00			Resident B's injury of	ha
		1 at 4:00 p.m., of the			unknown origin was reported to t appropriate agencies and	ne
		cy department physician			administrator on 3/2/11.	
		3/2/11, indicated				
		examined and had				
	_	ng, especially on the				
	_	t thigh extending down			TT 91 13 426 43	
	to the right glutes	al area. Bruising was also			How will you identify other residents having the potential to	, ho
	noted around her	anus. No perineal			affected by the same deficient	
	bruising was obs	erved. The resident also			practice and what corrective	
	had a small hema	atoma on the left side of			action will be taken	
	her forehead with	n some bruising. This				
		the bruising appeared to			Residents residing in the	
	_	ration suggesting minor			facility have the potential to be affected by the alleged deficient	
	trauma.				practice.	
					r	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC		COMPL	ETED
		155115	B. WIN			03/10/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			LASALLE AVE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		1	BEND, IN46617		
					. 52.15,		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG		_	DATE
					· A facility wide skin sweep was completed by the Licensed	p	
	Review of the closed clinical record of				nurses on 3/3/11 to ensure no oth	ner .	
	Resident B on 3/	7/11 at 11:25 a.m.,			skin alterations including bruises		
	indicated the res	ident's diagnoses			other injuries.	. 01	
	included, but we	re not limited to			Any identified concerns v	vill	
	Parkinson's disea	ase and dementia with			be corrected as necessary and/or		
	psychosis. The	resident resided in the			reported to administrator or design	-	
	1 ^ *	or to her transfer to the			and state agencies as indicated in	the	
	_	it to her transfer to the			facility policy.		
	hospital.						
	The educionism N	Airiman Data Cat (MDC)					
	The admission Minimum Data Set (MDS)						
	assessment, dated 2/11/11, indicated the				What measures will be put into		
		organized thinking			place or what systemic changes		
	patterns and exh	ibited physical and verbal			you will make to ensure that the		
	symptoms towar	ds others. The resident			deficient practice does not recu	r	
	required extensiv	ve assistance with all					
	activities of daily	y living and was able to			Facility staff were re-educ		
		ssistance from staff. The			on the Abuse Prohibition, Report and Investigation policy & proce	-	
	resident also util				by the Ombudsman on March 23		
	resident disc din	ized a warker.			2011.	,	
	Davious of the m	urses' notes from 2/18/11			L.P.N. #1 is no longer		
					employed at the facility.		
	to 3/2/11 indicate	ed the following:			· Staff re-education regardi	ng	
					facility policy & procedure for		
		l confused, made several			investigation of injuries of unkno	own	
	attempts to get o				source.		
	2/19/11 restless,	, constantly getting up and			Staff re-education regardi	ng	
	trying to walk. p	hysically aggressive,			timely reporting of unusual occurrences or injuries of unknown	TVD.	
	constantly movin	ng.			origin to the Administration or	vv 11	
	1	constantly getting up,			designee and other state agencies	s.	
	poor safety awareness. 2/21/11 requires 1:1 care for safety awareness, constantly standing up and				Emphasizing the importance of		
					adhering to these policies &		
					procedures.		
	trying to get out	of chair.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPLETED	
		155115	B. WIN			03/10/2011	
NAME OF I	PROVIDER OR SUPPLIER		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	KOVIDEK OK SUPPLIER			1121 E	LASALLE AVE		
		REHABILITATION CENTER		<u>.</u>	I BEND, IN46617		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ON
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)	DATE	
	_	lown, tries to walk and			How the corrective action(s) wil	,	
	was tired within two minutes.				be monitored to ensure the	`	
	2/25/11 up during night, constantly rolling				deficient practice will not recur	,	
	herself on floor r				i.e., what quality assurance		
	_	0 a.m., unable to sit still.			program will be put into place		
	2/27/11 up and down as usual				A ((A1) D. 1.11.41	,	
	2/28/11 difficult to keep in bed, up within				· An "Abuse Prohibition an Investigation" CQI tool will be	a	
	five minutes. W	hen ambulating wants to			completed by the Director of		
	sit down, just dro	ops and staff has to catch			Nursing/Designee Weekly X's 4		
	her in the air or e	else she ended up on the			weeks, Monthly X's 2 months, ar	ıd	
	floor.	•			Quarterly thereafter.		
	3/1/11 1:1 care to	o ensure no falls. Edema			· Any identified trends or		
	noted in both fee				concerns will be addressed		
		at on the floor. Physician			immediately. Data will be submitted to	the	
		nt sent to the hospital for					
		ubsequently admitted.		CQI committee for review plans initiated as needed.			
		was lacking in the nurses'			•		
		_			What is the date by which the		
	notes to indicate	any bruising was noted.			systemic changes will be comple	ted	
	During interview	on 3/9/11 at 2:45 p.m.,			Compliance Date: April 7, 2011		
	with CNA#3, wh	no gave the resident a					
	•	I, indicated she notified					
		w and fresh bruises to the					
		area and buttocks. The					
		he nurse (LPN#1)					
	proceeded to me	,					
	proceeded to me	asare the areas.					
	Review of the sh	lower sheet for 3/1/11					
		had documented "all					
	bruises registered in tx (treatment) book						
	on purple sheets.						
	D. 1. 04						
	Keview of the wo	ound skin evaluation					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		INSTRUCTION	(X3) DATE SURVEY COMPLETED 03/10/2011		
NAME OF	PROVIDER OR SUPPLIEI	<u>"</u> {		1	ADDRESS, CITY, STATE, ZIP CODE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		1	LASALLE AVE I BEND, IN46617		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	sheets with multisheets were date measurements of bruises were dood be determined the reported in the hadepartment reported in the bruises and thigh area. She about the bruises and thigh area, anything about the hadepartment had hadepartmen	with Administrator and 11 at 9:20 a.m., the LPN is the nurse in charge of a stated no one told her is around the breast area. She didn't remember ineasuring the areas. Instrator began about the CNA telling her darker bruises, she it indicated she did not do them because she thought by noted on the purple stated she should have the sand initialed new ones for the fresh bruises. She is she paged the supervisor is n't in the facility yet and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/10/2011			
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN46617					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	entitled "Definition of Courrence/Even Administrator or Events that are restricted in Director of Courrences and ISE sources, an injurinjury of unknown the following consource of the injuring any person or the could not be expanded and the extent of the the injury or the observed at one of the incident of in bruising, repeat the second in the incident of incident	nt" provided by the a 3/8/11, indicated " equired to be reported to operations, DNS, irector of Clinical DHinjuries of unknown y should be classified as on source when both of aditions are met: 1. The ary was not observed by a source of the injury lained by the resident ary is suspicious because injury or the location of number of injuries particular point in time or ijuries over time (multiple						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/10/2011	
NAME OF PROVIDER OR SUPPLI	REHABILITATION CENTER	1	STREET A	ADDRESS, CITY, STATE, ZIP CODE LASALLE AVE I BEND, IN46617			
PREFIX (EACH DEFICII	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
record reviews provide groom care for 1 resid for 9 residents who were unable activities of date resided in 2 of Residents: C,F. Findings include 3/7/11 between the following residents, C, H, I observed to have dirty fingernail and 2 identified on the nursing 1. Review of the at 10:30 a.m., for the diagnoses is limited to confiquarterly Mining assessment, day resident requires of one person for hygiene. The pridentified a province of the pr	f, I, J, K, L, M, N, O and P.	F03	12	It is the practice of this provider to residents who are unable to carry activities of daily living receives necessary services to maintain go nutrition, grooming, and personal and oral hygiene. What corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice Resident # C: The resident has received ADL care including care per the Plan of Care. Resident # H: The resident has received ADL care including care per the Plan of Care. Resident # I: The resident received ADL care including nail care per the Plan of Care. Resident # J: The resident has received ADL care including care per the Plan of Care. Resident # K: The resident has received ADL care including care per the Plan of Care. Resident # K: The resident has received ADL care including care per the Plan of Care. Resident # L: The resident has received ADL care including care per the Plan of Care. Resident # M: The resident has received ADL care including care per the Plan of Care. Resident # M: The resident has received ADL care including care per the Plan of Care. Resident # N: The resident has received ADL care including care per the Plan of Care. Resident # N: The resident has received ADL care including care per the Plan of Care. Resident # N: The resident has received ADL care including care per the Plan of Care.	out the the tod , e s the nail thas t nail ut nail tt nail tt nail tt nail	04/07/2011	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/10/2011		
		155115	B. WIN			03/10/20	UTT
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
CARDIN	AL NURSING AND	REHABILITATION CENTER		1	LASALLE AVE I BEND, IN46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	all ADLs (activit	ies of daily living).			care per the Plan of Care. Resident # P: The residen	nt	
		1: 1 1 0/5/11			has received ADL care including		
		e clinical record on 3/7/11			care per the Plan of Care.		
	at 11:00 a.m., for Resident H indicated the						
		ed, but were not limited			How will you identify other		
		ementia and macular			residents having the potential to affected by the same deficient	be	
	1 ~	he admission MDS			practice and what corrective		
	· ·	d 10/21/10, indicated the			action will be taken		
		lly dependent on staff for					
	personal hygiene	5.			Residents who reside in the	ne	
	3. Review of the clinical record on 3/7/11				facility have the potential to be affected by the alleged deficient		
					practice.		
	· ·	r Resident I indicated the			· Licensed nurses, Qualified	d l	
	diagnoses includ	ed, but were not limited			Medication Aides, and Certified		
	to CVA (cerebral	vascular accident) and			Nursing Assistants were re-educa	ited	
	diabetes. The pl	an of care, dated 12/2/10,			to providing ADL care by the	1/	
	indicated a self c	are deficit and decreased			Director of Nursing Services, and designee, on 03/31/11, and ongoi		
	functional ability	and the resident required			as needed.	.115,	
	assistance with A	DLs due to impaired			Noncompliance with	L	
	cognition.				facility policy and procedur		
					may result in employee		
	4. Review of the	clinical record on 3/7/11			re-education, and/or		
	at 10:28 a.m., for	r Resident J indicated the			disciplinary action up to and	i	
	diagnoses includ	ed, but were not limited			including termination.		
	to dementia and	legal blindness. The plan					
	of care, dated 2/2	23/10, identified a need			What measures will be put into		
	for limited to ext	ensive assist with ADLs			place or what systemic changes		
	due to the diagno	osis of dementia.			you will make to ensure that the		
					deficient practice does not recui	·	
	5. Review of the	clinical record on 3/7/11			· Licensed nurses, Qualified	d l	
	at 10:30 a.m., for	r Resident K indicated the			Medication Aides, and Certified		
	1	ed, but were not limited			Nursing Assistants were re-educa	ited	
	ı •	is and depression. The			to providing ADL care by the	1/0"	
	•	•			Director of Nursing Services, and	1/01	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/10/2011		
AND PLAN	SUMMARY S (EACH DEFICIENT REGULATORY OR annual MDS ass indicated the res extensive of one personal hygiene 6. Review of the at 10:35 a.m., for diagnoses include to anoxic brain of The plan of care the resident was	REHABILITATION CENTER STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) essment, dated 12/28/10, ident required the person for maintaining	A. BUILD B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE LASALLE AVE BEND, IN46617 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) designee, on 03/31/11, and ongoi as needed. The Director of Nurs Services is responsible to monitor for facility complia in providing necessary care and services to the residents. Charge nurses will make care rounds at least 2 times a shift to observe for quality resident grooming. How the corrective action(s) will be monitored to ensure the	COMPL 03/10/20	ETED
	at 10:40 a.m., for the diagnoses inclimited to demer The annual MDS 10/12/10, indicate the extensive assimaintaining personal Review of the at 10:45 a.m., for diagnoses include to blindness and quarterly MDS at 10/21/10, indicate totally dependent hygiene.	clinical record on 3/7/11 r Resident M indicated cluded, but were not atta and osteoporosis. S assessment, dated ted the resident required distance of one person for sonal hygiene. clinical record on 3/7/11 r Resident N indicated the led, but were not limited hypertension. The assessment, dated ted the resident was ton staff for personal e clinical record on 3/7/11 r Resident O indicated the			deficient practice will not recursive., what quality assurance program will be put into place A Resident Care Rounds of tool will be utilized weekly x 4, monthly x 4, and then quarterly, a monitor compliance with necessar care and services. The governing CQI committee will review the d. If the threshold for compliance is met, an action plan will be developed. What is the date by which the systemic changes will be complete. Compliance Date: April 7, 2011	CQI to to try g ata. not	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/10/2011			
	PROVIDER OR SUPPLIER	IL REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN46617					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE		
	to anxiety with be and confusion. 3/1/11, identified extensive assist verification diagnosis of dem 10. Review of the 3/7/11 at 10:50 as indicated the diagnosis of dem 10. Review of the 3/7/11 at 10:50 as indicated the diagnost limited to particular quadriparesis dusting significant change dated 9/30/10, in totally dependently d	e clinical record on .m., for Resident P gnoses included, but were ranoid schizophrenia and e to spinal stenosis. The ge MDS assessment, dicated the resident was t on staff for personal espectively with Unit d #2, the Unit Managers idents' nails should have aned on a daily basis and id refuse, the staff should						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/10/2011			
CARDINA		REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 E LASALLE AVE SOUTH BEND, IN46617					
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155115	B. WIN		- <u></u> -	03/10/2011	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOIT EIEK				LASALLE AVE		
CARDINA	AL NURSING AND F	REHABILITATION CENTER		SOUTH	I BEND, IN46617		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	E02	TAG	DEFICIENCE)	DATE	
F0323		ation, interviews and	F03	23	F 323	04/07/2011	
SS=D		he facility failed to			1 323		
	ensure a resident, identified by the facility				It is the practice of this provider t	О	
	as cognitively impaired, received adequate				ensure that the facility ensures that		
		event the resident from			the residents environment remain	S	
	_	d in the facility without			free of accident hazards as is possible and each resident received	20	
		edge. The resident was			adequate supervision and assistan		
	_	middle of the night in			devices to prevent accidents.		
	-	y area. This deficient					
	•	1 of 1 residents reviewed			What corrective action(s) will be	e	
	for wandering in the sample of 6.				accomplished for those residents	h.	
					found to have been affected by t deficient practice	ne	
	Resident: C				deficient practice		
					· Resident #C is provided		
	Findings include	:			supervision to ensure staff have		
					knowledge of residents whereabo	I	
	During orientation	on tour on 3/7/11 at 10:05			at all times and she had a wander guard placed		
	a.m., Resident C	was observed seated in a			The dietary door had a nev	w I	
	wheelchair in the	hall. A clip alarm was			lock installed.		
	attached to the re	sident's wheelchair.					
					How will you identify other	_	
	Review of the cli	nical record on 3/8/11 at			residents having the potential to affected by the same deficient	be	
	10:30 a.m., indic	ated the resident's			practice and what corrective		
	diagnoses include	ed, but were not limited			action will be taken		
	to confusion, den	nentia, depression,					
		ion and glaucoma.			Residents residing in the		
					facility have the potential to be affected by the alleged deficient		
	The significant c	hange minimum data set			practice.		
	_	nt, dated 9/14/10,			· Nursing staff were		
	indicated the resi	dent had short term			re-educated on the supervision of	·	
	memory impairm	nent, periods of			residents 3/8/11 & 3/31/11 and		
		did wander. She required			ongoing.	atad	
		areas of activities of daily			 Dietary staff were re-eduction environmental procedures 	aleu	
					on environmental procedures		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED	
		155115	B. WIN			03/10/2011	
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIEF	8		1	LASALLE AVE		
CAPDIN	AL NITIDSING AND	REHABILITATION CENTER		1	BEND, IN46617		
	AL NONOINO AND	REHABIEITATION CENTER					
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		1
TAG	†	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	living. The resid	dent's primary mode of			regarding locking the kitchen 3/8	/11	
	transportation w	as the wheelchair.			& 3/31/11.	.,	
					Noncompliance with facil		
	Review of a repo	ortable incident provided			policy and procedure may result employee disciplinary action up		
	by the Administrator on 3/8/11, indicated				and including termination.	.0	
	1 *	found in the facility			and merading termination.		
		•			What measures will be put into		
		ne night shift hours on			place or what systemic changes		
		imately 2:30 a.m., by the			you will make to ensure that the		
	nursing staff. Tl	ne resident was found			deficient practice does not recu	r	
	sitting in her wheelchair with unopened mayonnaise packets on her lap and asking						
					· Residents at risk for		
	for "chicken, I'm hungry." The resident				wandering were identified and ca	ire	
	was unable to recall why or how she went				plans have been reviewed and		
	into the kitchen.				revised, as needed. Residents with assistance		
	into the kitchen.				devices are monitored by license	d	
	D	141. Alice A. Accellation and a m			nurses and nursing assistants for	u	
	_	w with the Administrator			presence and function no less tha	n	
		p.m., she indicated she			each shift and with resident conta		
	1 ^	e evening nurse, who last					
	saw the resident	between 8:00-8:30 p.m.,			How the corrective action(s) will	1	
	and the 2-10 shift	ft CNAS indicated they			be monitored to ensure the		
	last observed the	e resident between 8:15			deficient practice will not recur	,	
		m. The Administrator			i.e., what quality assurance		
	1 -	the night shift CNAS			program will be put into place		
		•			A COI to al milli be until	.	
	1 ` *	(00 a.m.) indicated they			· A CQI tool will be utilized weekly x 4, monthly x 2 and	ı	
		check on the resident at			quarterly, to monitor compliance		
	the beginning of				with supervision and assistance		
	Administrator in	dicated CNA#4 went to			devices to prevent accidents. The	e	
	make rounds at a	around 1:00 a.m., and			governing CQI committee will		
	realized the resid	dent was not in her room.			review the data. If the threshold t	or	
	The nursing staf	f then began a facility			compliance is not met, an action	plan	
		arch between 1:00 a.m.			will be developed.		
		hey heard the resident in					
	the kitchen and t	_					
	ine kitchen and t	men caned the			What is the date by which the		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155115			A. BUILI B. WING	DING	NSTRUCTION	COMPL 03/10/2	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	B. WING	STREET A 1121 E I	DDRESS, CITY, STATE, ZIP CODE LASALLE AVE BEND, IN46617		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	door, which had entered the area. indicated the dood department autor staff left the kitch shift the night coresponsible for loinside. Interview on 3/9/evening cook incompartment autor staff left the kitch shift the night coresponsible for loinside. Interview on 3/9/evening cook incompartment got into Interview on 3/9/evening cook incompartment g	matically locked when the nen and at the end of the ok was responsible was ocking the doors from the 11 at 1:45 p.m., with the licated she locked the nd was unsure of how the			systemic changes will be complete. Compliance Date: April 7, 2011		